Barnabas Health

Saint Barnabas Medical Center
Barnabas Health Ambulatory Care Center

BREAST CENTER—MALE PATIENTS

To be completed by the patient

Note: if there is deodorant or powder on your breast or underarms, please wash it off before you have the mammogram. Ask the technologist for help if you need it.

NAME_____ DATE OF BIRTH_____AGE ____

REFERRING MD_____ TODAY'S DATE_____

YOUR PRIMARY LANGUAGE _____

1. Have you had a mammogram before? ☐ YES ☐ NO
   Where and When?_____
2. Is this mammogram routine? ☐ YES ☐ NO
   Reason for mammogram_____
   (Lump, discharge, retraction, thickening, pain)
3. Have you or any blood relative had breast cancer? ☐ YES ☐ NO
4. Are you taking any medication? ☐ YES ☐ NO
   Which type?_____How long?_____
5. Have you had surgery on your breast? ☐ YES ☐ NO

ALLERGIES ☐ None

LATEX _____ REACTION _____
MEDICATION _____ REACTION _____
FOOD _____ REACTION _____
OTHER _____ REACTION _____

Patient's Signature_____

TO BE COMPLETED BY THE TECHNOLOGIST

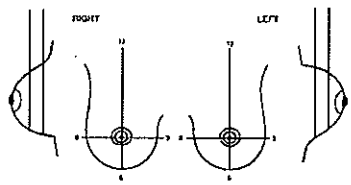
☐ Breast surface (moles, keloids)
☐ Nipples – Inverted? Discharge? How long?_____
☐ Breast size discrepancy Which?_____
☐ Implants?_____

Comment_____

Patient identity (name and date of birth) and site verified-

Tech signature_____

Date and Time_____



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